Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $12,648.13 for date of service 02/26/01.
   b. The request was received on 02/26/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC-60 and Letter Requesting Dispute Resolution
   b. UB-92
   c. TWCC 62 forms
   d. Carrier EOB(s)
   e. Medical records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC-60 and Response to a Request for Dispute Resolution
   b. TWCC 62 forms
   c. SOAH Decision
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307(g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 07/05/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 07/09/02. The response from the insurance carrier was received in the Division on 06/24/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file

III. PARTIES' POSITIONS

1. Requestor: Letter dated 06/28/02:
"…Code Section 133.304 specifically provides 'the explanation of benefits **shall include the correct payment exception codes**….On the EOB provided by the Carrier, both codes 'M' or 'F' were indicated for each billed amount, …code 'M' does not apply to billed amounts that have an established 'MAR'….**Despite prior notification to the Commission and additional requests by (Provider) to forward this correspondence to their legal representative, the Commission continued to forward this correspondence to the incorrect fax number.**"

2. Respondent: Letter dated 06/24/02:
"THE CARRIER REALIZES THAT PROVIDERS MUST ABSORB A SIGNIFICANT AMOUNT OF THEIR CHARGES WHEN TREATING MEDICARE, HMO, AND PPO PATIENTS. THESE REIMBURSEMENTS ARE VALID COMPARISONS ACCORDING TO THE ALJ DECISIONS NOTED IN SOAH…ACCORDING TO THE FIRST TWO DECISIONS, THE MEDICARE RATES ARE VALID REIMBURSEMENTS FOR ASC SERVICES AND REPRESENT COST EFFECTIVE CARE. THE CARRIER, IN DETERMINING…A 'FAIR AND REASONABLE RATE' DID CONSIDER THE MEDICARE, PPO AND HMO PAYMENTS, AND REVIEWED THE COMMISSION'S OWN GUIDELINES FOR ACUTE CARE. ACUTE CARE GUIDELINES STATE THAT $1118.OO IS A VALID REIMBURSEMENT FOR A FULL DAY OF OUTPATIENT CARE, OR APPROXIMATELY 24 HOURS…OUTPATIENT OR AMBULATORY SURGICAL SERVICES ARE THOSE THAT REQUIRE LESS THAN 90 MINUTES ANESTHESIA TIME AND LESS THAT [sic] FOUR HOURS OF RECOVERY. THIS MEANS THE PATIENT RECEIVES CARE FROM THE FACILITY FOR ¼TH OF THE TIME OF BEING IN AN INPATIENT SETTING FOR A FULL DAY, AND THE FACILITY IS PAID AT THE **EQUIVALENT OF** A ONE DAY INPATIENT STAY. **THE ACUTE CARE FEE GUIDELINES WERE USED AS A CONSIDERATION**…**IN DETERMINING REIMBURSEMENT**…**THIS DOES NOT MEAN THAT INPATIENT GUIDELINES WERE APPLIED TO THIS SERVICE**….THE PROVIDER HAS BILLED $14,116,35 [sic] FOR THIS OUTPATIENT SERVICE…THE PATIENT COULD HAVE BEEN ADMITTED TO THE FACILITY FOR AROUND THE CLOCK CARE FOR **TWELVE DAYS**…."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1&2), the only date of service eligible for review is 02/26/01.

2. The provider billed a total of $14,116.36 for the disputed date of service per the TWCC 60.

3. The carrier reimbursed a total of $1,118.00 per the TWCC 60 and the denial EOB is "M - IN TEXAS, OUTPATIENT SERVICES ARE TO BE PAID AS FAIR AND REASONABLE ."

4. The amount in dispute per the TWCC-60 for the disputed date of service is $12,648.13.

V. RATIONALE

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…" (bolded for emphasis)
The Medical Fee Guidelines General Instructions (VI) discuss that if a MAR value has not been established for a CPT code, reimbursement shall be, "…at the fair and reasonable rate." ASC(s) do not have a MAR value.

Section 413.011(b) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Rule 133.307 (g) (3) (D) states, "if the disputes involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1…"

The carrier has submitted sufficient documentation of its methodology and therefore, meets the requirements of Commission Rule 133.304 (i).

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine what would be fair and reasonable reimbursement for the services provided. The provider did submit EOB(s) from the carrier. The EOB(s) submitted from the carrier did not indicate what procedure or services were performed nor were any ICD-9 codes listed. Several of the EOB(s) were incomplete. The carrier did submit a methodology, however, regardless of the carrier's application of it's methodology, lack of methodology, or response, the burden is on the provider to show that the amount of reimbursement requested is fair and reasonable. The provider's documentation is EOB(s) or is based on EOB(s). The willingness of the carrier in the years 2000 and 2001 to provide reimbursement at or near the billed amount does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011(b) of the Texas Labor Code. The provider states in the letter of request for medical dispute resolution, that an extensive review of payments and reimbursements were made by various carriers from the geographical areas of Texas for services in involving both work-related, non-work related injuries, managed care patients, and non-workers' compensation patients with an equivalent standard of living. The information was not included in the dispute packet. Based on the evidence available for review, the provider did not meet the criteria of Rule 413.011 (b) or Rule 133.307 (g) (3) (D) and did not prove that the carrier's reimbursement is not fair and reasonable. Therefore, the provider is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 8th day of August 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm